Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WAYNE SOIGNIER MD
PO BOX 741865
DALLAS TX 75374

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-1212-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Required testing requested by the designated doctor."

Amount in Dispute: $160.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The dispute notice was placed in the carrier representative box on December 16, 2010. No response was received.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13,2010	97750-FC	$160.00	$160.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
   28 Texas Administrative Code §134.204 titled *Medical Fee Guideline for Workers' Compensation Specific Services,* effective March 1, 2008, sets out the reimbursement guidelines for the disputed services.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 29, 2010
   - 1 (W1) – Workers Compensation State Fee Schedule Adjustment
   - 2 (B13) – previously paid. Payment for this claim/service may have been provided in a previous payment.

   Explanation of benefits dated November 16, 2010
   - 2 – the charge for this procedure exceeds the fee schedule allowance

Issues

1. Did the respondent support its denial reasons?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent denied payment for the disputed service based upon "W1 – Workers Compensation State Fee Schedule Adjustment", "Payment for this claim/service may have been provided in a previous payment", and "the charge for this procedure exceeds the fee schedule allowance." The requestor billed 16 units for an FCE; the respondent reimbursed 12 units. 28 Texas Administrative Code §133.3 states, "any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill." The respondent did not provide specific detail to support its reduced payment.

2. 28 Texas Administrative Code §134.204 (g) states, "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) (1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:
   (1) A physical examination and neurological evaluation, which include the following:
   (A) Appearance (observational and palpation);
   (B) Flexibility of the extremity joint or spinal region (usually observational);
   (C) Posture and deformities;
   (D) Vascular integrity;
   (E) Neurological tests to detect sensory deficit;
   (F) Myotomal strength to detect gross motor deficit; and
   (G) Reflexes to detect neurological reflex symmetry.
   (2) A physical capacity evaluation of the injured area, which includes the following:
   (A) Range of motion (quantitative measurements using appropriate devices) of the injured joint/region; and
   (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
   (3) Functional abilities tests, which include the following:
   (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
   (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
   (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
   (D) static positional tolerance (observational determination of tolerance for sitting or standing).

   The requestor billed according to 28 Texas Administrative Code §134.204 (g); therefore recommend additional reimbursement as follows:

   - DWC conversion factor $54.32 ÷ Medicare conversion factor $36.8729 x participating amount $29.51 = $43.4732 x 16 units = $695.57 minus carrier's previous payment $480.00 = $215.57. The Table of Disputed Services lists the amount in dispute as $160.00, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $160.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $160.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		MAY 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.